REVIEWS.

ART. XIV.—*The Practice of Surgery.* By THOMAS BRYANT, F.R.C.S., Surgeon to Guy's Hospital; with 507 illustrations. 8vo. pp. 984. Philadelphia: Henry C. Lea, 1873.

A VERY few years ago the American student wishing a text-book on surgery was compelled to choose either "Gross," "Erichsen," or "Druitt;" the first of great value as a work of reference, but too large, and entering too much into details to be well adapted for an undergraduate; the others in the American reprints decidedly behind the times, successive editions being issued without material change.

But within the last three years we have had a new edition of Erichsen, new in fact as well as in name, actually revised and enlarged; a work by Ashhurst; a fifth edition of Gross; a work by Hamilton, and, now, a treatise on the Practice of Surgery by Mr. Bryant of Guy's.

The work under review claims to be "a manual of the Practice of Surgery," to "deal only with essentials and principles," "not intended to compete with such valuable works as Paget's 'Surgical Pathology' and Holmes's 'System;'" no subject having been "consciously omitted which comes under the notice of the general surgeon, although the rightly recognized specialties of eye, ear, and dental surgery have been excluded." The introductory chapter deserves the careful reading of every one, student or practitioner, who may take up the volume—diagnosis, diatheses, and cachexias being considered. Two rules are laid down as proper always to be observed in making a diagnosis, rules simple and obvious enough, but yet oftentimes neglected to the injury of the patient and discredit of the surgeon.

> 1st. "That in the diagnosis of a case every possibility of its nature should be run over and entertained, a conclusion being arrived at by a process of elimination; each possibility being considered separately and weighed, the most probable should be finally accepted; a diagnosis framed on probabilities alone being most hazardous." And, 2dly. "Let it be an invariable rule of practice in every case of injury or disease, to compare the sound side of the body with the affected one."

Respecting the first of these, it is very truly said that "to form a diagnosis of a case mainly on probabilities as indicated by its symptoms, may be a ready, but it will ever be a rash proceeding. To form it on the possibilities, will always be a safe, although, perhaps, a less expeditious practice."

As regards diatheses it is declared that—

> "Disease in subjects who have these diatheses [*strumous, scrofulous, tuberculous*] is precisely identical in its essential nature with the same disease as found in others who have them not. It may be modified in its course by the diathesis, but it is the same disease. . . . . It is important for the surgeon to bear this fact in mind, for there can be little doubt the expressions, strumous disease and scrofulous disease, have had an injurious influence on the practice of sur-

gery. They have too often led the surgeon (and misled the public) to regard a local affection in a strumous or scrofulous subject as incurable, as depending on some general and not a local cause. In disease of the joints this evil has been much felt, and should be corrected."

Of cachexias it is written—

> "Clinically I read the meaning of a cachexia as a looking ill, perhaps very ill, but it has no other definite signification—looking ill from cancer, looking ill from abdominal, rectal, suppurative, or syphilitic disease."

Of the many subjects treated of in the work we purpose noticing, chiefly, the "surgery of the circulatory system," "hernia," and "diseases of the urinary organs."

To the first of these about seventy-five pages are devoted, the several chapters treating of "wounds of the heart and arteries;" "hemorrhage and its treatment;" "diseases of the arteries;" "aneurism;" the "ligature of arteries;" "injuries and diseases of the veins." Wounds of the heart are, of course, declared "generally mortal," but under the head of gunshot wounds we are somewhat astonished to find the statement that such wounds of this organ "are always fatal, although not always instantaneously so."

In Fischer's tables 7 cases out of 51 of this sort are reported recovered from, in five of which the balls remained in the organ. In the case reported by Latour the patient lived six years, and in Balch's case life was prolonged eighteen years. In cases like these, even though death may be the indirect result of the injuries received, it is hardly correct to say that the wounds were mortal.

In treating of wounds of arteries, Mr. Bryant calls attention to the declaration of Sir James Paget that though a small wound of an artery followed by "repeated hemorrhages, at uncertain intervals," may heal by granulation, "the event is too unlikely to justify the waiting for its occurrence," and even if it takes place there is likely to follow a form of traumatic aneurism, "in which the sac is chiefly formed of scar-tissue, which closed the wound in the artery, and then yielded to the pressure of the blood." "Hemorrhage and its treatment" are considered at some length, and there is presented (as might have been expected from the author) a very interesting plea for torsion as the best method of arresting the flow of blood from a divided artery.

> "In a physiological point of view there is no method at the surgeon's command more perfect for the control of hemorrhage than that of torsion; for unlike acupressure, which uses one only of nature's hæmostatic processes, or the ligature, which is a foreign body in a wound, and becomes a source of danger by undoing at a later period of the case what has been done at an earlier by nature's own efforts, it utilizes to the utmost all the physiological processes employed by nature to prevent and arrest bleeding, and places them in the most favourable position to take effect." "Plastic lymph is poured out by the divided tunics in the same way as it has been shown to be in the application of the ligature, and it acts the same part in cementing all the arterial tunics and clot together; but there is this difference between the two forms of practice, that where the ligature has been used, the ulceration of the vessel that is necessary to allow of its escape may undo all that nature has done to seal the artery and prevent hemorrhage; whereas, when torsion has been efficiently performed and the hemorrhage arrested, no subsequent action is liable to undo the good work that has been done, or hinder the permanent closure of the vessel."
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> "The physiological arguments in favour of torsion are very great, and the practical advantages seem to be no less, for after three years' experience of the practice applied to vessels of all sizes, the femoral being the largest, I have

had no mishap. Wounds have united more rapidly and kindly. Primary union being the rule, there has been less constitutional disturbance after operation, and consequently less liability to traumatic fever, pyæmia, and other complications, such as we are all too familiar with in the practice of surgery. I have had stumps heal in a week, and patients up in two weeks, without one single drawback; rapid and uninterrupted convalescence following the operation. In other cases equally good success can be recorded."

"When a true antiseptic ligature has been found, by which a vessel can be secured without the introduction of any permanent cause of irritation, the above comparison will not hold good; but at present it is not in existence, although Mr. Lister's investigations in that direction with catgut ligatures steeped in carbolic acid are encouraging in the extreme."

Of acupressure, the opinion is expressed that "as a general mode of arresting hemorrhage, it seems improbable that it will hold its ground, indeed it is but little practised at the present time. It is, however, a valuable mode of temporarily arresting hemorrhage in certain cases where the ligature and torsion are inapplicable."

Reference is made to Speir's artery-constrictor, which, it is thought, "may be useful for obstructing arteries in continuity, as for aneurism. For divided vessels it has no advantage over torsion."

Of transfusion, it is said that "the smaller the quantity of blood transfused the better," and that "the operation has not hitherto been a very successful one."

Arteritis and atheromatous disease are considered together, since, according to the views of our author, there is "no question as to there being a close relationship between the two affections. Virchow and Billroth, abroad, Wilks and Moxon, in this country, have fairly proved that atheroma of an artery is due to a subinflammatory process." Here, as Mr. Bryant himself says, is one of the points of difference between himself and many of the writers of surgical text-books. That atheroma is likely to be followed by the formation of aneurism is denied, Moxon's views being accepted, that "the more inflammatory changes tend more to produce aneurisms than do the atheromatous patches;" atheroma causing the formation of a pulpy mass in the coats at any spot, generally thick and hard and unyielding, and not giving way to pressure, so as to form an aneurism."

The definition given of aneurism ("a sacculated tumour communicating with the canal of an artery, and formed from its walls") we do not like as well as the one more frequently given ("a pulsating tumour filled with blood and communicating with an artery"), since it does not strictly include what have been described as diffused, spurious, or consecutive aneurisms. As respects the division into true and false our author says:—

"When all the coats are involved in the sacculated dilatation it has been the fashion to describe it as being *true;* when the two inner coats have given way, and the external or cellular alone remains, *false;* but I agree with Holmes, that it is impossible, clinically, to perceive any difference between true and false aneurisms at the time at which they generally come under observation. The true become false as they grow, and the false are far the more common."

Respecting the termination of aneurisms, it is said that "a thoracic or abdominal aneurism may burst into a mucous tract, such as the trachea, pharynx, œsophagus, or intestine, and when it does Dr. Gairdner has shown that it proves fatal by a recurrent hemorrhage through a small orifice; when it bursts into a serous cavity, such as the pleura, pericardium, or peritoneum, it destroys by a sudden hemorrhage through a large aperture." However true this may be as a rule, it is a rule having its exceptions, as we have ourselves had occasion to see, a case of thoracic aneurism under our care having terminated fatally in less than two minutes from a first and terrific hemorrhage into the left bronchus.

The treatment by compression, the "Dublin method," is declared to have "now found a firm place in surgery"—

> "Modern experience fairly proving the soundness of Dr. W. Murray's observation, that the principle on which the rapid method rests is clearly 'the complete stagnation of a mass of blood in the aneurism until it coagulates.' For this purpose digital pressure is undoubtedly the best; when this cannot be made available, mechanical means must be employed, and the nearer it approaches to digital pressure the more undoubtedly it is to be preferred. . . . . When digital pressure can be employed and is successful, it is more rapid than any other, and, as a rule, less painful."

When it cannot be applied, the next best is instrumental pressure. Attention is called to the fact that the circulation through an artery as large as the femoral can be controlled for hours by the "finger applied directly on the vessel, and the weight adjusted upon the finger." That this is worth remembering, every one who has had anything to do with digital compression will readily acknowledge.

Combined flexion and compression is referred to, and a case mentioned in which by alternating these methods cure was effected in eighteen hours. We have elsewhere referred to a case in which in less than two hours consolidation was effected by the combined methods.

"The treatment by ligature should only be entertained when that by compression in one of its forms is inapplicable, or has proved unsuccessful." Notice is made of the recurring feeble pulsation "a day or two after the application of the ligature," even in successful cases, and of the persistent pulsation in cases of "vasa aberrantia;" elsewhere the usual principle is laid down that the operator "should satisfy himself when the vessel is on the needle that pulsation exists, and that pressure upon it arrests pulsation in the aneurism," and this rule should have been noticed in these paragraphs on ligation and its after-results. It should be borne in mind, also, that sometimes (as we saw in a case of popliteal aneurism several years since), after ligature of the main trunk a superficial vessel running over the tumour becomes so much enlarged that its pulsation is very apparent, and may for the moment give rise to the belief that pulsation is still present in the aneurism. Ligation on the distal side, it is declared, "cannot be recommended with any confidence except in carotid aneurism;" but is "justifiable" in innominate aneurism. The treatment by manipulation, "based on natural, although exceptional, processes," may be "used in appropriate cases when all other treatment is out of the question."

The treatment by galvano-puncture "can only be entertained in exceptional and otherwise hopeless cases." That by injection "has not been satisfactory;" the production of coagulation "in the sac of an aneurism by such means is a dangerous proceeding." A passing notice is made of Langenbeck's treatment by injection of ergotin, but we infer that Mr. Bryant does not expect much from it. In the treatment of nævus by ligature attention is called to the fact that, when the nævus is large, the tying of a part of it may by extension of inflammatory action destroy the whole. The chapter on the ligature of arteries is introduced by some general remarks worthy of careful reading, having reference to the place at which and the manner in which the ligature should be applied, and the after-treatment of the case. In the list of operations upon the abdominal aorta no mention is made of Watson's. Ligature of the common carotid is pronounced "a dangerous operation, and sometimes a difficult one, . . . only to be done when all other means of treatment are inapplicable, or have been found ineffectual, and for aneurism it ought not to be performed unless the treatment by digital compression has been rejected. Ligature of the subclavian in the first part of its course has been performed about seven times, but never with success; it is an unscientific as well as an unsuccessful operation, and for disease it is scarcely a justifiable proceeding; for a wound it may perhaps be entertained." We are surprised at Mr. Bryant's reporting ligatures as made "about" so many times; the actual number of accepted cases should be stated definitely. In point of fact, as Prof. Gross's table shows, *twelve* operations upon the first part of the subclavian have been made, all fatal. Mr. Bryant's colleague, Mr. Poland, reported the number at eleven in his table given in Guy's Hospital Reports. If our author questioned the correctness of the report of some of these cases, he should have stated how many, and whose he rejected. In ligaturing the external iliac, division of "the transversalis fascia the whole length of the wound is an unnecessary and dangerous proceeding." The common iliac is said to have been tied "about thirty-nine times." Ashhurst, two years ago, said forty-five times. Ligature of the common femoral is favourably considered on account of the success attending the operations of the Porters and Macnamara of Dublin; the propriety of its performance, however, is declared "a question requiring more experience before it can be decided."

Guthrie's method of ligating the posterior tibial is regarded with much less favour than that by division of the tibial origin of the soleus muscle; indeed the statement is made that "modern surgeons have universally rejected" the Guthrie method. That all modern surgeons have *not* done so, Mr. Bryant will be convinced by reading "Gross" and "Hamilton." We have ourselves made the operation four times on the living subject, and repeatedly on the cadaver, and know that, so far as we are concerned, the Guthrie operation is altogether the easier and more satisfactory.

In cases of wounds of veins, "when pressure is enough to arrest hemorrhage, the ligature is not required; when it fails or is inapplicable, the ligature may be fearlessly employed. The dread of setting up phlebitis by interfering with the veins is based on prejudice and not on practice; it is doubtless due to the influence of the authority of great names who have pronounced against it. . . . *Veins may be ligatured or twisted with impunity.*" (The italics are our own.) Respecting varicose veins it is declared, that

> "General testimony also admits that this disease is as common in the higher ranks of life as in the lower; that it is as common in women as in men; that it is as frequent on the right side as on the left, and more frequently is found on both sides; that it is a disease of the young as much as of the middle aged; that it is found in the strong and healthy as in the feeble and cachectic; in fact, that it is found under every condition of life, and in every variety of subject. Some evidence exists that gout and hereditary predisposition are efficient causes, with local injuries and prolonged muscular exertion. . . . No special form of ulcer can be said to exist as the result of varicose veins, in fact there is no such thing as a 'varicose ulcer.'" The radical cure of varix "is to be thought of only when the vein is hopelessly deteriorated, or, as is so frequently the case, it is inflamed and painful and threatens to burst; it should be entertained only in cases in which all palliative and other treatment is inapplicable, or has failed."

Respecting the subjects of "Hernia," they are declared to belong more largely to the working classes, because these latter constitute the greater part of any given population ; there is in many cases an hereditary predisposition, "a third of all cases acknowledging a history of having a ruptured parent." This fact is not usually called attention to in any marked manner, yet, if it is a fact, it is as important as it is curious, and should be borne in mind by those having professional oversight of the families of the ruptured. Females are declared "as liable to inguinal hernia as they are to femoral, the inguinal being most common in early life, the femoral in middle and old age. . . . Before menstruation the femoral is so rare as to be almost unknown." Though it has long been known that inguinal hernia in the female is of not infrequent occurrence, yet a very considerable proportion of practitioners seem to altogether forget that such is the case, and have greatly less expectation of finding such a hernia in the female than femoral in the male. The general symptoms and treatment of reducible, irreducible, inflamed, and strangulated hernias are clearly and succinctly set forth. It is as usual advised to return the "inflamed and injured contents of a hernial sac into the abdominal cavity," Hutchinson's and Girard's belief that it is such return that usually gives rise to peritonitis, being declared "an assumption which the facts as hitherto known do not bear out."

Statistics are quoted clearly proving that "gangrene of the intestine and artificial anus are more common after femoral than inguinal hernia," and "that ulceration in the line of stricture with fecal extravasation is more frequent in inguinal than in femoral hernia, and that where it is found in the latter, it is generally from rupture of the bowel from forcible taxis."

The use of chloroform prior to the attempt to return the bowel by taxis is very highly recommended ; "chloroform, taxis, and operation are the three great means of securing reduction upon which the surgeon ought successively to rely." When under chloroform the return of the protrusion is not quickly and easily effected, the persistent use of the taxis is strongly reprobated.

> "As a rule, with the patient under chloroform, a hernia that is capable of being reduced by taxis goes up on the gentlest manipulation, and when this result does not take place, force will not only not succeed, but must prove injurious. . . . With the patient under chloroform a femoral hernia of average size, that of a walnut, should never be manipulated for more than two minutes. . . . In large femoral herniæ, inguinal or umbilical, five minutes may possibly be allowed ; but the quarter and half hours' manipulation that is too frequently talked about, is dangerous in the extreme."

It seems to us that the time permitted to be given to the taxis before proceeding to herniotomy is too short. Perhaps a little more latitude in this respect would save the necessity of operating in one-third of the cases of inguinal and two-thirds of the cases of femoral hernia, as Mr. Bryant says is necessary. There is an astonishing difference between eminent surgeons in the number of operations they make for strangulated hernia, the inguinal variety particularly, and it is by no means the fact that those who operate least frequently have the largest number of fatal cases. The operation itself, our author insists, and very properly too, should be performed while the patient is under the influence of the anæsthetic given to facilitate reduction by the taxis, delay being not only dangerous in itself, but also, to some extent, because it necessitates subjecting the patient to a risk, however slight it may be, in again producing anæsthesia. Mr. Bryant is a strong advocate of the "minor operation," *i. e.*, the freeing of the constriction without opening the sac, whenever by such operation the stricture is relieved.

> "The surgeon who opens the sac in *every* case, clearly often does so unnecessarily. . . . So far as statistics go, or are of value towards the solution of this point, they are in favor of not opening the sac. . . . Whenever *the taxis is applicable* to a strangulated hernia and fails, herniotomy without opening the sac is applicable, and where reduction is effected nothing more is needed. Where reduction cannot be effected, or some doubtful piece of something remains in the sac, or the contents of the sac have not gone back with their normal rush, or the symptoms persist, or any doubt about the condition of the parts at the neck of the sack is raised, an exploration of the sac and its neck is absolutely necessary."
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> "Whenever the taxis is *inapplicable*, that is when the strangulation has been of so long a duration, the symptoms so severe, fecal vomiting so persistent, and local as well as general symptoms indicate the probability that the strangulated gut has died, or is dying, and whenever, during the application of the taxis, by the sudden collapse or yield of the tumour without its reduction, the fear is excited of some rupture of the bowel having taken place, herniotomy by the minor operation is inapplicable; the sac must be laid open and its contents dealt with."

Drawing down of the neck of the sac and introduction of the finger into the abdominal cavity under ordinary circumstances are pointedly condemned. We are pleased to see stress laid on encouraging the inactivity of the bowel after reduction either by taxis or operation. The young practitioner needs some strong backing in his opposition to the administration of cathartics so often urged, almost demanded, by patients and still more by friends.

Some space is devoted to "displaced herniæ," cases demanding the closest attention and readily overlooked or misunderstood. The great thing to be remembered with reference to them is, that, though seeming reduction has been effected, "the surgeon has failed to experience that sudden jerk so characteristic of the escape of the hernia," and "after the effects of the chloroform have passed away all the symptoms of strangulated bowel recur and perhaps with increased force. When this condition is found, there is but one form of practice to follow, and that is the exploration of the sac. The surgeon must then draw out the bowel from the sac through its false orifice, and, having freely divided the true neck or abdominal orifice of the sac, replace the intestine." The "radical cure" by invagination, since "even when the cure has been effected the wearing of a truss is still an essential point of practice," is pronounced "an operation that cannot be recommended." Wood's operation is considered ingenious and to be employed "when the radical cure is called for," though the necessity of wearing a pad for many months and always "when the patient is about to be subjected to violent strains or lifting," tends much to do away with the value of the operation.

> "For my own part, I believe that where a hernia can be kept up by a truss, and the patient is likely to remain in a civilized country, where trusses can be obtained, any operation for the radical cure is an unjustifiable one; to risk the life of the patient on the theory of a cure, with the probability that the patient will be rendered less liable to its descent, when a truss has to be worn subsequent to the operation as a matter of safety, is a practical delusion."

In operating for femoral hernia the lifting up of a fold of skin and dividing it from within outwards is not advised, since it "is in a measure dangerous, for I have seen Mr. Key with the point of his knife divide all the tissues outside the sac and the sac itself in perforating the skin fold."

Attention is called to the fact, that in umbilical hernia the tumour always increases *downwards;* and when herniotomy is made and the sac opened, "it is an exceptional occurrence for any cure to follow, whereas when the sac is not opened, a good result may be looked for." While so much is said, and well said too, on the subject of hernia, no reference is made to the treatment by "pneumatic aspiration," though in the preceding chapter on "injuries of the abdomen," Mr. Bryant says that he has been "led to think that even in a large hernia its strangulation might be relieved by a like operation [tapping with fine trocar and canula], and a natural reduction take place," and in another place he says that "in one case I had to puncture the bowel with a trocar and canula, and draw off the air it contained before I succeeded [in reducing]. No harm followed this step, and the patient did well."

A short chapter is devoted to "trusses," and we doubt not that many patients in our own country would be much benefited if medical men would, as a rule, have an oversight of trusses, instead of, as is too often the case, leaving the whole matter in the hands of instrument-makers.

The section on "Diseases of the Urinary Organs" is introduced by a few paragraphs on the diseases of the kidneys, organs the healthy or unhealthy condition of which directly affects the prognosis, not only in surgical diseases of the bladder and urethra, but of all other parts of the body. As Mr. Bryant very truly says, "to the surgeon a thorough knowledge of renal pathology is as requisite as it is to the medical practitioner."

"Diseases of the Bladder" are next considered, and we notice that with reference to the severer forms of cystitis and vesical ulceration it is declared that "it is a question whether an incision into the bladder, as for lithotomy, would not be a sound practice, the urine then flowing away as secreted and a chance given to the bladder to recover itself; at any rate the operation would give relief." Such operation has been made, as by Batty, of Georgia, and in cases of cystitis in the female the establishment of a vesico-vaginal fistula is a recognized proper and valuable method of treatment. As a differential diagnostic sign between polypoid tumours and vascular growths of the bladder, there is given the usual absence and presence respectively of hemorrhage from the bladder. The sentence in which this is particularly brought out is one of those specimens of not overly-clear English of which there are many in the book. "In this point they [villous growths] differ widely from the polypoid tumours last considered, for in these hæmaturia is usually the first symptom that attracts notice, and the most persistent; indeed it is often the only one." Now to which shall a student understand "these" to refer, "polypoid tumours" standing nearest, or "they" more remore. Four chances out of five, if he had not carefully read what went before, he would conclude that it was in cases of polypoid tumours that early and persistent hemorrhages occurred.

"Incontinence in the child" our author thinks had best be treated by the *tr. ferri chloridi*, belladonna ranking next; chloral he has in many cases found useless. The mechanical methods of treatment, including that recommended by Sir Dominic Corrigan, he does not think well of, regarding them as "wrong in principle."

Respecting prostatic enlargements, the "bar consisting of the elastic structure and mucous membrane of the neck of the bladder," our author has "never known to be found," and gives it "only on the authority of the names quoted," viz., Guthrie, Mercier, and Thompson. The specific gravity of normal urine is given as from 1020 to 1030, higher than we think it will be generally found. Every reader should feel the truth of the statement that "urinary deposits are not of themselves diseases, and are not to be dealt with as such; they are always to be accepted as indications of disease, functional or organic, in some of the working organs or other parts of the machinery of the body."

In the chapter on "Stone" the rule that has been by other surgeons so strongly insisted on is given, "to *hear* as well as to *feel* the stone." Respecting the comparative merit of lithotomy and lithotrity, it is declared that "in *children* lithotomy ought to be the rule, lithotrity the exception. In *adults* lithotrity ought to be the rule and lithotomy the exception." If renal disease exists, the cutting rather than the crushing operation should be resorted to, especially if there are associated bladder complications. The recent case of Louis Napoleon is likely to give rise to no little discussion upon this very subject. Preferring lithotrity under ordinary circumstances in adult patients labouring under stone, Mr. Bryant enters at some length into the consideration of the two methods of its performance, the "English" in which the stone is made to fall into the grasp of the instrument, and the "Civiale" in which the calculus is picked up with the instrument, the former being the one which he has most usually adopted. He states that he has on several occasions successfully crushed at a single sitting stones "upwards of an inch in diameter." The particular lithotrite to be employed is regarded as a matter of much less importance than perfect familiarity with the instrument employed, "no surgeon being justified in attempting to crush a stone in the bladder of a living patient until by practice he has learned to have perfect command over the instrument he has to employ, and a thorough knowledge of its capabilities." Of the various lithotomy-operations preference is given to the lateral, and the lateral after the method of Aston Key, statistics being given which are considered by the author as proving the greater safety and success of this method. It is declared that at Guy's "during the last fourteen years seventy patients have been cut consecutively without a death." The introduction of a gum-elastic tube after the operation, and its retention for a couple of days, is said to be "quite unnecessary."

Respecting pelvic cellulitis and peritonitis, it is declared "an open question as to how far the renal disease or the operation is the cause." Calculus in the female is to be removed by rapid dilatation when this is practicable, in other cases by lithotrity unless the bladder is "too contracted, inflamed, or ulcerated," in which latter conditions vaginal lithotomy is to be performed and the opening subsequently closed by sutures. "Slow dilatation of the urethra is to be avoided and all urethral lithotomy condemned."

Of strictures of the urethra, "at least half the cases are found in subjects who have not suffered from gonorrhœa, and when gonorrhœa might be put down as an assigned cause, the use of injections for its cure does not appear to have had any positively injurious influence in producing a stricture." The "tour de maitre" mode of passing the catheter "is named only to be condemned; in the hands of a skilled surgeon it may be done with impunity, but in those of an inexperienced man it is fraught with danger."

In the treatment of strictures gradual dilatation is preferred, and that by retained catheters of gradually increased calibre. The "immediate treatment" is not apparently a favourite with Mr. Bryant, who considers it no more reliable than gradual dilatation, and more likely to be followed by "bad and even fatal effects." Laminaria stalks are regarded as dangerous, and not to be employed in perineal strictures. "Internal urethrotomy, except for strictures at the orifice of the urethra and within the penis, is not an operation for which much can be said." After external urethrotomy, the keeping in of a catheter is, Mr. Bryant is "somewhat disposed to think, hardly needed; . . . but more experience is called for before the omission of its use can be recommended." It is so recommended by some of our surgeons most familiar with strictures and their treatment. Mr. Cock's method of making perineal section is preferred to all others. It seems to us that in many cases the old operation is decidedly the better one, since a new urethral canal is formed, and neither a perineal fistula nor "a complete bar to procreation" must be the result. We have, in a case of, to us, impermeable stricture, made a new channel over an inch long, through which the patient after the healing of the wound readily and regularly passed a No. 12 sound.

Of the various causes of death from stricture the chief one is renal disease, and it is remarked that "every person the subject of renal disease stands, as it were, on the edge of a precipice, and the slightest adverse wind may send him down." The existence of "true spasmodic stricture" is admitted.

"Of 129 examples of retention from simple organic stricture, 109 were successfully treated by means of catheterism, warm baths, and opium; and in 20 cases only, or in 15.8 per cent., were any other operative measures called into requisition. In all of these 20 examples, the bladder was punctured per rectum, with complete success." This latter operation is, as usual, the one recommended. No mention is made of supra-pubic aspiration which has lately been reported as highly successful, and at the same time altogether devoid of danger and able to be repeated again and again with perfect safety.

Brief notice must be taken of certain other points which have attracted our attention. Among the comparatively new things in surgical practice are skin-grafting, pneumatic aspiration, antiseptic dressings, and the therapeutical applications of electricity. The first is declared a very valuable method of treating large ulcers, "its adoption rendering many cases curable that were not so previously, facilitating the cure of as many more, and giving interest to a class of cases that had formerly but little." Small pieces of skin are decidedly preferred, and it is directed that they be placed near the margins of the sore rather than in its centre. Taking the grafts from another individual is regarded as very objectionable "from the risk that is necessarily run of introducing into the blood of the living subject some new or poisonous element." It seems to be believed by our author that the cicatricial tissue resulting from the skin-grafting is more liable to "break down and ulcerate" than the old skin, which is very probable.

Pneumatic aspiration is favourably spoken of in the paragraphs on tapping of the chest, of hydatid tumours, and of serous cysts.

The antiseptic treatment is brought before the reader in several paragraphs, largely in Mr. Lister's own words, Mr. Bryant declaring himself, "no convert as yet to the theory upon which it is based, nor to the great value of the special practice based upon it; neither is yet proved." The use of carbolized catgut ligatures is several times referred to, and mention is made of the entire disappearance within twelve months of such a ligature applied to a pedicle dropped back into the abdominal cavity after ovariotomy.

So far as we have noticed, no reference is made to the use of electricity in the treatment of tumours or organic strictures; we have already quoted what is said respecting its employment in cases of aneurism; in hydatid tumours we find that it "should certainly be employed when simple tapping fails to cure."

In the chapter on "Fractures," the immovable dressing is favourably spoken of, and special attention is called to the "Bavarian" plaster dressing, which is pronounced "by far the best immovable apparatus we possess, as good for joint cases as for those of fracture." Our own experience in its use leads us to fully coincide with these views.

In the chapter on "Elephantiasis," it is stated that "in some cases, if not in all, where the main artery of the limb is ligatured and the vascular supply to the disease cut off, a recovery takes place." It would appear from the investigations of M. Marduel, that there is much reason to fear in such cases that the recovery will not prove a permanent one.

Of the various anæsthetic agents in use, chloroform, and a mixture of chloroform, ether, and alcohol, are evidently preferred by our author. He quotes approvingly Perrin's statement, that the "honor of the first public and authentic trial of surgical anæsthesia, by the aid of means newly discovered, belongs entirely to an obscure dentist, Horace Wells, of Hartford, Connecticut.

It is gratifying to our national pride to find an English writer making so many references to American surgeons as there are in the work under review. At least fifty-five of our surgeons, dead and living, are mentioned by name, and their papers or cases referred to. As might have been expected, some mistakes in names and places have been made. For example, Dr. Onderdonk, who first employed ligation as an antiphlogistic agent, is called Dr. Onderdant; the name of Dr. Hodges, of Boston, appears in several places as Hodge; that of Dr. Lidell, as Liddell; that of Dr. Speir, as Speirs; that of Dr. Detmold, as Detmolds; Dr. Nathan R. Smith, of Baltimore, is spoken of as Nathan Smith, of New York. Mistakes are also made in the names of journals; the "Medical Record" is in one place called the "Medical Mirror," and at least twice the "American Journal of the Medical Sciences" is called the "American Quarterly."

The national pride, to which we have just referred, is not so much gratified in finding the name of Lizars preceding that of McDowell in the list of the "earliest practical promoters" of ovariotomy.

Of the value of the work as a literary production we need not speak. It might have been written in better English, but it is with the matter not the manner that we are particularly concerned. Mr. Bryant is to be thanked for having given us a large number of new illustrations, representations chiefly of specimens in the museum of Guy's Hospital. There is some hope that we may, in time, be no longer vexed with the sight of those old stock engravings that have been constantly on duty for the last twenty years or more.

With this "Practice of Surgery" we are much pleased, and commend it to the notice of students and practitioners as a work containing a great deal of information respecting the diagnosis and treatment of surgical diseases and injuries. We have no hesitancy in recommending it as one of the best of the less than half a dozen works from which the student should select his text-book in surgery. P. S. C.